

Behavioral Health Integration

Introduction

The purpose of this document is to articulate the different phases in the overall behavioral health integration effort; to describe the three models; and to provide examples of some of the specifications that will be discussed in Phase 3.

Phases of Work

The behavioral health integration effort is a three-phase approach. In the first phase, conducted in 2011, the state determined that the existing organization of services should be changed, because of the fragmentation across somatic, mental illness, and substance use disorder services.

The second phase, now underway, involves determining what model should be pursued – a single fully-integrated program with a protected behavioral health carve-in (Model 1); a risk-based carve-out of behavioral health services (where the risk might be insurance and/or performance) (Model 2); or a fully-integrated model that consists of several managed care organizations (MCO) offering an array of services that would be sufficient for individuals with mild or moderate behavioral health needs, and a fully-integrated specialty MCO that offers a more comprehensive array of specialty behavioral health services for individuals with serious behavioral health needs (Model 3).

The third phase will involve establishing “specifications” for the selected model that would govern elements such as those described in more detail below.

The work at hand, in Phase 2, involves recommending a model.

Phase 2: Model

The selection of a model sets the framework for the program. The key factors that determine the type of financial model are the following: (1) fee-for-service or capitation; (2) covered benefits; and (3) covered populations.

- Fee-for-service (FFS) or capitation. One of the most essential elements in describing a model is whether the entity (or entities) managing the program bears insurance risk in the form of capitation. In a capitated model, the entity(ies) receive a per member, per month (PMPM) payment from Medicaid to provide care to their enrolled beneficiaries. The entity(ies) may chose to spend this money to deliver services outside of the traditional

Medicaid FFS benefit package. In a capitated model, providers are paid by the entity(ies) receiving the capitation payment(s), according to the terms of contracts between those parties. An MCO is an example of a capitated entity. An administrative services organization (ASO) model is a form of organized FFS model, because the ASO does not bear insurance risk, nor does it hold the contracts with the providers or set the providers' rates. Instead, the ASO manages the FFS program on behalf of the state, based on the state's rules for qualified providers, payment rates, and utilization criteria.

- Covered Benefits. The model also is determined by the benefits that fall within the purview of the entity(ies) managing the program. Determining whether specialty behavioral health benefits should be part of an MCO's role (Models 1 and 3), a capitated behavioral health organization (one version of Model 2), or an ASO (the other version of Model 2) sets the structure. Other benefits could be carved-in or carved-out, such as prescription drugs.
- Covered Populations. The model also is determined by which populations are included in which programs. For example, HealthChoice includes many populations, but several populations expressly are carved-out (i.e. their somatic services are paid FFS): Medicare-Medicaid dual eligibles; individuals who meet an institutional level of care (i.e., an institutional length of stay that will equal or exceed 30 days); and individuals eligible for the REM program who choose to be served in FFS. HealthChoice does NOT carve-out individuals with behavioral health needs; these individuals are included in HealthChoice (and PAC) for purposes of their somatic and substance use disorder treatment. In the Behavioral Health Integration work, a determination of which populations should be included in which services will be essential in settling on the model.

OPTION 1: Protected Carve-In

Model Description:

Under this model, Maryland would bundle funding for somatic care, mental health and substance abuse treatment in the HealthChoice program, and all benefits would be the responsibility of MCOs. The carve-in of behavioral health services would be "protected" because the model would ensure adequate and identifiable funding for behavioral health services, and the establishment of a responsible organization for each individual's total health care would provide a powerful incentive for integrated care and prevention. Any behavioral health savings would be re-directed to additional, innovative behavioral health benefits.

OPTION 2: Risk-bearing Carve Out

Model Description:

Under this model, Maryland would procure an organization(s) to manage behavioral health benefits (both substance abuse treatment services and mental health services) under some form of performance and/or financial risk model. If the contract involved insurance risk, the entity would be a “managed behavioral health organization”, or MBHO. “Insurance risk” would mean that the organization(s) would receive a PMPM payment for each covered individual based on an individual’s projected health care costs, no matter the individual’s actual health care costs. If the contract instead involved performance risk, but not insurance risk, the entity would be an ASO. “Performance risk” would mean a portion of the payment to the organization(s) would be dependent on the organization(s) meeting certain performance criteria. Either way, this entity would coordinate the services for which it has responsibility with the HealthChoice MCOs (who, in turn, would be responsible for coordinating with the MBHO or ASO).

OPTION 3: Specialty Behavioral Health MCO

Model Description:

Under this option, all HealthChoice MCOs would be responsible for providing the comprehensive benefit package for all services - somatic, mental health, and substance abuse – very similar to Option 1. Additionally, one or two Specialty MCOs would provide all services for the chronically mentally ill and recipients with a chronic substance abuse diagnosis (a carve-out like the Program of All-Inclusive Care for the Elderly (PACE)). Admission to the Specialty MCO would be based on either specific diagnoses, or based on reaching a level of severity as indicated by service utilization.

The Specialty MCO(s) would be responsible coordinating the more intensive needs of this population. The Specialty MCO would include “deep-end” mental health services such as Psychiatric Rehabilitation Programs (PRP), Residential Rehabilitation Programs (RRPs) and Mobile Crisis. This MCO would manage these intensive services and provide an integrated care plan that has a strong focus on the somatic needs of this population.

Phase 3: Specifications

The third phase of the process involves the specifications for the new system. It’s understandable that there is a great deal of interest in the specifics of how any given model would operate. Many of these “specifications” are independent of the model itself, and could be applied to any model. For illustration purposes, specifications include issues such as:

- Authorization/utilization rules. Establishing prior authorization rules, and/or utilization review rules, is independent of the model. For example, and for illustration purposes only, regardless of the model the state could contractually specify that (a) some services should be exempt from prior authorization (i.e., the beneficiary can self-refer), (b) outpatient therapy counseling should initially approved in an amount not less than ten visits, or (c) all residential and inpatient stays must be prior authorized.

- Quality measures and reports (that could also involve bonuses/sanctions). Identifying what measures the state should focus on when conducting contractual oversight is independent of the model. Potential measures could include beneficiary and provider satisfaction; access/utilization rates; HEDIS scores; readmission rates; and others. Determining the measures, setting relative financial weights (values) for each measure, and determining what portion of the overall financing to place in bonuses/sanctions are elements that are independent of the model.
- Any willing provider. Does the entity (or entities) managing the contract have the right to exclude any provider, or must the entity(ies) contract with “any willing provider”? Allowing the entity(ies) to selectively credential and contract with providers might result in higher quality (by excluding low-performing providers), and it might result in greater cost efficiencies (by contracting at rates based on scale and volume). On the other hand, excluding certain historic or potentially essential providers might narrow patient options and limit access.
- Provider rates. While the ASO model would simply utilize Medicaid’s FFS rates as the payment system, the rate structure in any capitated model could be established by specifications. Examples include: (a) mandating that the entity(ies) managing the program pay at least the Medicaid FFS rates unless the entity(ies) and provider agree to an alternative approach; and (b) mandating that certain “safety net” providers (somehow defined) are guaranteed certain rates, whereas all other providers’ rates are set through negotiation.
- Beneficiary protections. Certain kinds of beneficiary protections could be specified, independent of the model. For example, the state could compel the entity(ies), even an ASO in that type of model, to organize a beneficiary “advisory council”, a beneficiary “Ombudsman”, and similar requirements. Additional protections, regarding issues like a guaranteed right to a second opinion in certain circumstance (as a covered benefit), the operation of a 24/7 beneficiary call center, and an “expedited” grievance and appeals system also could be required in any model.
- Staffing requirements. In any model, the state could specify the credentials for specific behavioral health practitioners in clinical leadership positions, such as the credentials of staff who perform behavioral health utilization management.